

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Worcester 9408

Village or City near Snow Hill 189

2 FULL NAME Henrietta Allen

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 351

St. _____ Ward _____

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female	4 COLOR OR RACE Black	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single
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6 DATE OF BIRTH 4 25, 1913

(Month) (Day) (Year)

7 AGE 1 yrs. 4 mos. 10 ds.	If LESS than 1 day, hrs. OR min. ?
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8 OCCUPATION (a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Md.

10 NAME OF FATHER Loring Allen

11 BIRTHPLACE OF FATHER (State or country) Md.

12 MAIDEN NAME OF MOTHER Maggie Sturgis

13 BIRTHPLACE OF MOTHER (State or country) Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Loring Allen

(Address) Newark, Md.

15 Filed 9/4, 1914 LeRoy Smith

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept. 4, 1914

(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from 191... to 191..., 191...

that I last saw h alive on 191..., 191...

and that death occurred on the date stated above, at 8 P.m.,

The CAUSE OF DEATH* was as follows:

no doctor in attendance
had deep cold & cough
mother died recently with
consumption (Duration) yrs. mos. ds.

Contributory
Secondary

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
(Signed) LeRoy Smith L. Reg., M.D.
9/4, 1914 (Address) Snow Hill

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,
if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Cedar Chapel Cem. DATE OF BURIAL 9/5, 1914

20 UNDERTAKER Wm. S. Williams ADDRESS Snow Hill

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age.

For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer*—*Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonacum, etc.*, *Carcin-*

*oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthma," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g., sepsis, tetanus) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)*

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED OCT 5 1914 BUREAU, V. S.
DEC 4 1914 BUREAU, V. S.
Sent to Bureau, V. S.
by Local Registrar

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH
County... Worcester

9409

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 355

Village or City... Berlin. (No.)

Md.

St.: Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED
(Write the word)

Married

6 DATE OF BIRTH

Date. Not Know, 1843
(Month) (Day) (Year)

7 AGE

71 yrs. — mos. — ds.
If LESS than
1 day, hrs.
OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer)

Farmer

9 BIRTHPLACE

(State or country)

Md.

PARENTS

10 NAME OF FATHER

Linton Ayers

11 BIRTHPLACE OF FATHER

(State or country)

Md.

12 MAIDEN NAME OF MOTHER

Baret Ayers

13 BIRTHPLACE OF MOTHER

(State or country)

Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mary Ayers

(Address)

Berlin Md.

15

Filed

1914

H. L. Holloway

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Sept. 29, 1914
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from

Sept 22, 1914, to Sept. 29, 1914

that I last saw him alive on Sept 28, 1914

and that death occurred on the date stated above, at 1 p.m.

The CAUSE OF DEATH* was as follows:

Malaria from

(Duration) yrs. mos. ds.

Contributory Secondary
Secondary Sudden failure of heart
due to pneumonia (Duration) yrs. mos. ds.

(Signed) H. L. Holloway, M. D.

(Address) Berlin Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

Germantown Cemetery Oct. 1, 1914
DATE OF BURIAL

20 UNDERTAKER

J. W. Burleigh & Co. Berlin Md.
ADDRESS

REVISED UNITED STATES STANDARD

CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary foreman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*) For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the DISEASE causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Anæmia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Mastitis," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent death state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *scaphis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

BUCKAU D. V. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH
County... Worcester
Village or City... Bishop

9410

120

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 353

St. Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Mary Ethel Bishop

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED
Female	White	DIVORCED (Write the word)

6 DATE OF BIRTH	Sep	23	1877
	(Month)	(Day)	(Year)

7 AGE	37	0	mos.	/	ds.	if LESS than 1 day, ... hrs. OR min. ?
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8 OCCUPATION	(a) Trade, profession, or particular kind of work... House-wife.
(b) General nature of industry, business, or establishment in which employed (or employer)	

9 BIRTHPLACE (State or country)	Maryland
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10 NAME OF FATHER	Peter Blades Bishop,
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11 BIRTHPLACE OF FATHER (State or country)	Maryland.
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12 MAIDEN NAME OF MOTHER	Rachel Davis.
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13 BIRTHPLACE OF MOTHER (State or country)	Maryland.
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14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant)	Rachel Davis'
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15 (Address)	Bishop, Md.
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Filed Sept 24, 1914	Griseth Rayne
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REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH September 24, 1914.
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1914, to Sept. 24, 1914,

that I last saw her alive on Sept. 23, 1914.

and that death occurred on the date stated above, at 8.15 Am.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis

(Duration) 1 yrs. mos. ds.
Contributory Mitral regurgitation.
(Secondary)

(Signed) J.R. Bishop (Signature) (Duration) yrs. 2 mos. ds.
9/24/1914, 1914 (Address) SHOWELL, MD.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL

Family Cemetery (Signature) DATE OF BURIAL Sept 25, 1914

20 UNDERTAKER P. F. Watson ADDRESS Sillyville Del.

REVISED UNITED STATES STANDARD

CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary engineer*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples:

(a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeeper* who receive a definite salary), may be entered as *Houscwife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Scravant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease

causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonacum*, etc. *Carcin-*

oma, *Sarcoma*, etc., or _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. For example: *Measles* (disease causing death), **20 d.**; *Bronchopneumonia* (secondary), **10 d.** Never report mere symptoms or terminal conditions, such as "Asthma," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Malaria," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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OCT 2 1914
BURLAU, V. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH
County Worcester 9411
94

Village or City Snowfield (No.)

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 351

St. _____ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Dick F. Butter

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Female</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Married</u>
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6 DATE OF BIRTH <u>Oct.</u>	(Month)	<u>1857</u> (Day)	(Year)
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7 AGE <u>56 yrs. 11 mos. 0 ds.</u>	If LESS than 1 day, ____ hrs. OR ____ min. ?
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8 OCCUPATION (a) Trade, profession, or particular kind of work. <u>Housework</u>	(b) General nature of industry, business, or establishment in which employed (or employer)
--	--

9 BIRTHPLACE (State or country) <u>Maryland</u>	
--	--

10 NAME OF FATHER <u>Hiram Phillips</u>	
--	--

11 BIRTHPLACE OF FATHER (State or country) <u>Maryland</u>	
--	--

12 MAIDEN NAME OF MOTHER <u>Dick Taylor</u>	
--	--

13 BIRTHPLACE OF MOTHER (State or country) <u>Maryland</u>	
--	--

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Alonzo Butter</u>	
--	--

(Address) <u>Giddings B. P. O.</u>	
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15 Filed <u>9/13/1914</u>	LeRoy Smith
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REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept. 11th, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Sept. 20th, 1914, to Sept. 11th, 1914, that I last saw him alive on Sept. 8th, 1914,

and that death occurred on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Brain hemorrhage followed by Paralysis

(Duration) yrs. 10 mos. 27 ds.

Contributory Valvular disease Secondary Heart Arterial Blood

(Duration) yrs. ____ mos. ____ ds.

(Signed) Paul Jones, M. D. Sept. 12th, 1914 (Address) Snowfield Md

* State the DISEASE CAUSING DEATH, or, In deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place _____ yrs. _____ mos. _____ ds. In the _____ State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,
if not at place of death?

Former or
usual residence _____

19 PLACE OF BURIAL OR REMOVAL Gosawango Church DATE OF BURIAL Sept. 13, 1914

20 UNDERTAKEN W. H. Head ADDRESS Snowfield

REVISED UNITED STATES STANDARD

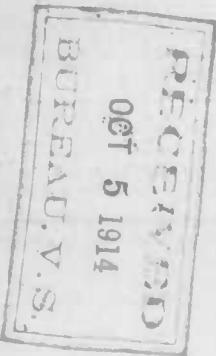
CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Turner* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary foreman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housmaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Masles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Anemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "*Puerperal septicemia*," "*Puerperal peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railroad train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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¹ PLACE OF DEATH Baltimore		9412
County _____		28
Village or City Baltimore	(No.)	
² FULL NAME Minnie E. Clarke		
PERSONAL AND STATISTICAL PARTICULARS		
³ SEX Female	⁴ COLOR OR RACE White	⁵ SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) Widow
⁶ DATE OF BIRTH July 27		, 1866 (Month) (Day) (Year)
⁷ AGE 48 yrs. 2 mos. 7 ds.	If LESS than 1 day, hrs. OR min. ?	
⁸ OCCUPATION (a) Trade, profession, or particular kind of work Housekeeping		
(b) General nature of industry, business, or establishment in which employed (or employer) Musical Instrument		
⁹ BIRTHPLACE (State or country) Baltimore Co.		
¹⁰ NAME OF FATHER Stephen Mills	¹¹ BIRTHPLACE OF FATHER (State or country) Baltimore Co.	
¹² MAIDEN NAME OF MOTHER Mary Donahoe	¹³ BIRTHPLACE OF MOTHER (State or country) Baltimore Co.	
¹⁴ THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Miss Annie Mills (Address) Baltimore City, Md.		
¹⁵ Filed 9/30, 1914	Ephraim Hellman	REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 350

St.; Ward)

[If death occurred in
a hospital or institution,
give its NAME instead
of street and number.]

MEDICAL CERTIFICATE OF DEATH

¹⁶ DATE OF DEATH
Sept 5, 1914 (Month) (Day) (Year)

I HEREBY CERTIFY, THAT I attended deceased from
May 5, 1914, to Sept 5, 1914,

that I last saw her alive on Sept 29, 1914,

and that death occurred on the date stated above, at 12:15 P.M.

The CAUSE OF DEATH* was as follows:

Inflammation tuberculosis

Mary Gross
(Duration) — yrs. — mos. — ds.

Contributory
Secondary
Grodal lymphatic
Bronchitis
(Duration) — yrs. — mos. — ds.

(Signed) R. Heebel, M.D.
Sept 5, 1914 (Address) Baltimore City, Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

¹⁸ LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds

Where was disease contracted,
If not at place of death?

Former or usual residence

¹⁹ PLACE OF BURIAL OR REMOVAL
Baltimore City, Md. DATE OF BURIAL
Sept 5, 1914

²⁰ UNDERTAKER
Leonard Brown ADDRESS
Baltimore

REVISED UNITED STATES STANDARD

CERTIFICATE OF DEATH

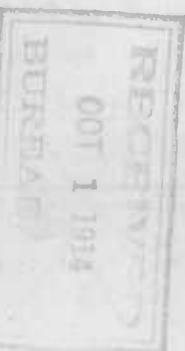
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Plauter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry; and therefore an additional line is provided for the latter statement; it should be used only when needed. - As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Saleman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housmaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*) For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avold use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcin-*

oma, Sarcoma, etc., or (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 d.; *Bronchopneumonia* (secondary), 10 d. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Dehility" ("Conjugal," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "*Puerperal septicemia*," "*Puerperal peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means of INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



BUREAU

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

1 PLACE OF DEATH		9413
County. <i>Worcester Co.</i>		(No.) <i>40</i>
Village or City <i>near Pocomoke</i>		
2 FULL NAME <i>Hester Claff</i>		
PERSONAL AND STATISTICAL PARTICULARS		
3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)
<i>Female</i>	<i>Colored.</i>	<i>Wedwed</i>
6 DATE OF BIRTH		(Month) (Day) (Year)
<i>Don't know</i>		<i>8/18/11</i>
7 AGE	8 OCCUPATION	9 BIRTHPLACE (State or country)
<i>97 yrs. 8 mos. 8 ds.</i>	<i>late General Storework</i>	<i>Don't know</i>
10 NAME OF FATHER	11 BIRTHPLACE OF FATHER (State or country)	12 MAIDEN NAME OF MOTHER
<i>Don't know</i>	<i>Don't know</i>	<i>() Alice</i>
13 BIRTHPLACE OF MOTHER (State or country)	14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE	
<i>Don't know</i>	(Informant) <i>John Coulborne</i> (Address) <i>Pocomoke City</i>	
15 Filed	16 DATE OF DEATH	17 I HEREBY CERTIFY, That I attended deceased from
<i>9/3 1914</i>	<i>Sept 18 1914</i>	<i>July 29 1914 to Aug 18 1914,</i>
		<i>that I last saw her alive on Aug 18 1914</i>
		<i>and that death occurred on the date stated above, at \$15 P.m.</i>
		The CAUSE OF DEATH* was as follows:
		<i>Exhaustion of Liver</i>
		<i>Don't know</i> (Duration) yrs. mos. ds.
		Contributory Secondary
		<i>M.E. Pastoreus</i> (Duration) yrs. mos. ds.
		(Signed) <i>Sept 3rd, 1914</i> (Address) <i>Pocomoke City Md.</i>

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. *350*

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

St.; Ward)

MEDICAL CERTIFICATE OF DEATH		
16 DATE OF DEATH	17 I HEREBY CERTIFY, That I attended deceased from	
<i>Sept 18 1914</i>	<i>July 29 1914 to Aug 18 1914,</i>	
(Month) (Day) (Year)	<i>that I last saw her alive on Aug 18 1914</i>	
	<i>and that death occurred on the date stated above, at \$15 P.m.</i>	
	The CAUSE OF DEATH* was as follows:	
	<i>Exhaustion of Liver</i>	
	<i>Don't know</i> (Duration) yrs. mos. ds.	
	Contributory Secondary	
	<i>M.E. Pastoreus</i> (Duration) yrs. mos. ds.	
	(Signed) <i>Sept 3rd, 1914</i> (Address) <i>Pocomoke City Md.</i>	
* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.		
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)		
At place	In the	
of death yrs. mos. ds.	State yrs. mos. ds.	
Where was disease contracted,		
If not at place of death?		
Former or usual residence		
19 PLACE OF BURIAL OR REMOVAL		DATE OF BURIAL
<i>Tunely Colored</i>		<i>9/3 1914</i>
20 UNDERTAKER		ADDRESS
<i>Phiburn & Son</i>		<i>Pocomoke</i>

REVISED UNITED STATES STANDARD

CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

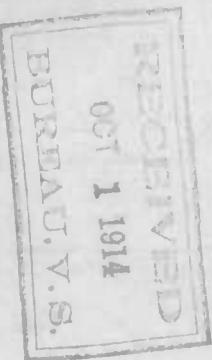
Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*; *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*) For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchoneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of (name origin, "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 d.; *Bronchopneumonia* (secondary), 10 d. Never report mere symptoms or terminal conditions, such as "Anæmia," "Anaemia" (merely symptomatite), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Confinement," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traëma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railroad train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *scrosis*, *telmuss*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH 9414
County Worcester

Village or City New Pomeroy (No.)

2 FULL NAME Cassie Collins

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 350

St. _____ Ward _____

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Yes 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married
(Write the word)

6 DATE OF BIRTH don't know, 1
(Month) (Day) (Year)

7 AGE 32 about If LESS than
yrs. mos. ds. 1 day, hrs.
OR min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE
(State or country) Worcester C

10 NAME OF FATHER James Schoolfield

11 BIRTHPLACE OF FATHER (State or country) don't know

12 MAIDEN NAME OF MOTHER Cassie Schoolfield

13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(informant) Noah Collins
(Address) Fremont City

15 Filed 9/28 1914 Ephraim Hellman
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept 4, 1914
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from Sept 2, 1914, to Sept 25, 1914,

that I last saw her alive on Sept 21, 1914.

and that death occurred on the date stated above, at 6 p.m.

The CAUSE OF DEATH* was as follows:

Pneumonia
Onset of lungs for facilitate

(Duration) yrs. mos. ds.

Contributory
Secondary

(Duration) yrs. mos. ds.

(Signed) D. C. Jackson, M.D.
Sept 28, 1914 (Address) Worcester

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds

Where was disease contracted, if not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL St. James 9/29 1914
DATE OF BURIAL

20 UNDERTAKER Stevenson & Son ADDRESS

Fremont

REVISED UNITED STATES STANDARD

CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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(a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Mauager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma*, *Sarcoma*, etc., of..... (name origin, "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railroad train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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UCT 1 1914

BUREAU, V. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

9415

County. Worcester

79

Village or City. Snow Hill (No.)STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 35

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Edward Collins

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED
(Write the word)MalewhiteMarried

6 DATE OF BIRTH

Feb 8, 1845
(Month) (Day) (Year)

7 AGE

69 yrs. 6 mos. 29 ds.

If LESS than
1 day, hrs.
OR min. ?

8 OCCUPATION

(a) Trade, profession, or
particular kind of work.(b) General nature of industry,
business, or establishment in
which employed (or employer)laborerfisherman

9 BIRTHPLACE

(State or country)

Maryland

PARENTS

10 NAME OF FATHER

James Collins

11 BIRTHPLACE OF FATHER

(State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Ann T. Hudson

13 BIRTHPLACE OF MOTHER

(State or country)

Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Frank Collins(Address) Goddard Rd. Dr.

15

Filed 9/4, 1914 by L. E. Boy Smith

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

9 2, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

8/15, 1914 to 9/2, 1914,that I last saw him alive on 8/15/14, 1914,and that death occurred on the date stated above, st. 6 P.M.

The CAUSE OF DEATH* was as follows:

Endocarditis (mitral regurgitation)(Duration) severe yrs. mos. ds.Contributory
Secondary(Duration) yrs. mos. ds.(Signed) E. W. Richart M. D.
9/4, 1914 (Address) Snow Hill Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL

Goddard Rd. Dr. Sept. 4, 1914

20 UNDERTAKER

ADDRESS W. T. Team Snow Hill

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balt., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD

CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various insults can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Cancer-*oma, *Sarcoma*, etc., of (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intervening) affection need not be stated unless important. Examples: *Musles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicemia," "puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railroad train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County Worcester

9416

45

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 351Village or City Snow Hill (No.)

St. _____ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Erastus S. Dashill

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male4 COLOR OR RACE White5 SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED
(Write the word) Married6 DATE OF BIRTH July 27

(Month)

(Day)

(Year) 18507 AGE 64 yrs. 8 mos. 25 ds.IF LESS than
1 day, ____ hrs.
OR ____ min. ?

8 OCCUPATION

(a) Trade, profession, or
particular kind of work. Dentist(b) General nature of industry,
business, or establishment in
which employed (or employer) Dental Work

9 BIRTHPLACE

(State or country) Maryland

PARENTS

10 NAME OF FATHER James A. Dashill11 BIRTHPLACE OF FATHER
(State or country) Maryland12 MAIDEN NAME OF MOTHER Susanna P. Dashill13 BIRTHPLACE OF MOTHER
(State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. W. D. Collins(Address) Snow Hill

15

Filed 9/22/1914

Leroy Smith

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 9/21

(Month)

(Day)

(Year) 1914

17 I HEREBY CERTIFY, That I attended deceased from

10/1/1914 to 9/21, 1914,that I last saw him alive on 9/21, 1914,and that death occurred on the date stated above, at 3:00 P.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Bladder
(Diagnosis verified by operation)
(Duration) 1 1/2 yrs. mos. ds.

Contributory
SecondaryCachexia (Duration) 3 1/2 yrs. mos. ds.(Signed) John H. Smith (Address) Snow Hill, M. D.

9/22, 1914

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,
if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

P. & C. Cemetery Snow Hill Sept. 23, 1914

20 UNDERTAKER

W. T. Head Snow Hill

DATE OF BURIAL

REVISED UNITED STATES STANDARD

CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma*, *Sarcoma*, etc., or (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Mastes*; *Whooping cough*; *Chronic catarrhal heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Mastes* (disease causing death), *29 ds.*; *Bronchomegaly* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Anemia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsey," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Truama," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "*Puerperal septicemia*," "*Puerperal peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, OR HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railroad train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH
County *Baltimore*

Village or City *Promenade* (No.)

9417

64

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. *307*

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME *Rutherford Dennis Davis*

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <i>Male</i>	4 COLOR OR RACE <i>White</i>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <i>Married</i>
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6 DATE OF BIRTH *January 15th*, 1829
(Month) (Day) (Year)

7 AGE *85 yrs. 8 mos. 10 ds.*
If LESS than
1 day, hrs.
OR min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work *Retired Farmer*
(b) General nature of industry, business, or establishment in which employed (or employer) *✓*

9 BIRTHPLACE
(State or country) *Baltimore Co.*

10 NAME OF FATHER *Isaac J. Davis*

11 BIRTHPLACE OF FATHER
(State or country) *Baltimore Co.*

12 MAIDEN NAME OF MOTHER *Jessie Webb*

13 BIRTHPLACE OF MOTHER
(State or country) *Baltimore Co.*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) *Mrs Annie Davis*

(Address) *Promenade*

15 Filed *Sept 26, 1914* Ephraim Hillman

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *September 25*, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from *Sept 21st*, 1914, to *Sept 25th*, 1914,

that I last saw him alive on *Sept 25th*, 1914,

and that death occurred on the date stated above, at *1:00 P.M.*

The CAUSE OF DEATH was as follows:

Heart attack
Appendectomy

(Duration) yrs. mos. ds.

Contributory *Arteriosclerosis*
Secondary *Gout*

(Duration) yrs. mos. ds.

(Signed) *A. Leobae*, M. D.
Sept 26, 1914 (Address) *Promenade*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL *Episcopal Cemetery* DATE OF BURIAL *Sept 27, 1914*

20 UNDERTAKER *Stowman Bros* ADDRESS *Promenade*

REVISED UNITED STATES STANDARD

CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonacum*, etc., *Carcin-*

oma, *Sarcoma*, etc., or (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: *Measles* (disease causing death), 29 d.; *Bronchopneumonia* (secondary). 10 d. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Seizure," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and QUALITY as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECE

OCT 1 1914

BUREAU, W. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

County Worcester

9418

21

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 351Village or City Snowfleece md (No.)

St. _____ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

John Dickerson

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Colored5 SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED
(Write the word)Single

6 DATE OF BIRTH

Sept 19, 1914
(Month) (Day) (Year)

7 AGE

yrs. mos. ds.

If LESS than
1 day, hrs.
OR min. ?

8 OCCUPATION

(a) Trade, profession, or
particular kind of work.None(b) General nature of industry,
business, or establishment in
which employed (or employer)None

9 BIRTHPLACE

(State or country)

Worcester Co. Md

PARENTS

10 NAME OF
FATHERHill Dickerson11 BIRTHPLACE
OF FATHER

(State or country)

Worcester Co. Md12 MAIDEN NAME
OF MOTHERDelia Hormone13 BIRTHPLACE
OF MOTHER

(State or country)

Worcester Co. Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Benjamin Hormone(Address) Snowfleece md

15

Filed 9/23, 1914

Leroy Smith

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Sept 23, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

191..... to

that I last saw h alive on , 191.....

and that death occurred on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

No physician
Convulsions from its built
until it died

(Duration) yrs. mos. ds.

Contributory
Secondary

(Duration) yrs. mos. ds.

(Signed) Paul Jones, M. D.
Sept 23, 1914. (Address) Snowfleece md*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT
CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCI-
DENTAL, SUICIDAL, or HOMICIDAL.18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS,
OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,
if not at place of death?Former or
usual residence

19 PLACE OF BURIAL OR REMOVAL

M. J. Weller cemeteryDATE OF BURIAL
Sept 24, 1914

20 UNDERTAKER

J. S. Williams

ADDRESS

Snowfleece md

REVISED UNITED STATES STANDARD

CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonitis, etc.*, *Carcinoma*, *Sarcoma*, etc., of..... (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "*Puerperal septicæmia*," "*Puerperal peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH
County Norchester

9419

Village or City Snow Hill (No.)

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 351

St. _____ Ward _____

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Mary Polk Green

PERSONAL AND STATISTICAL PARTICULARS		
3 SEX <u>Female</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Widowed</u>

6 DATE OF BIRTH
October 8, 1844
(Month) (Day) (Year)

7 AGE
69 yrs. 11 mos. 5 ds.
If LESS than
1 day.....hrs.
OR.....min. ?

8 OCCUPATION
(a) Trade, profession, or
particular kind of work...
none
(b) General nature of Industry,
business, or establishment in
which employed (or employer)
none

9 BIRTHPLACE
(State or country) Virginia

10 NAME OF
FATHER Edward H Conquest

11 BIRTHPLACE
OF FATHER
(State or country) Virginia

12 MAIDEN NAME
OF MOTHER Mary N. Broadwater

13 BIRTHPLACE
OF MOTHER
(State or country) Virginia

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Frank Hudson

(Address) Gidderit Md

15 Filed 9/15/1914 by Leroy Smith

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH September 13, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from
Sept. 9, 1914, to Sept. 13, 1914,

that I last saw h... in alive on Sept. 13, 1914,
and that death occurred on the date stated above, at 11:45 A.M.

The CAUSE OF DEATH* was as follows:

Edema & Lung
Coccyx & failure
Chronic Bright's
(Duration) Chronic yrs. mos. ds.

Contributory Secondary
Chronic Bright Disease
(Duration) Chronic for years yrs. mos. ds.

(Signed) Walter G Richards, M. D.
Sept. 14, 1914 (Address) Snow Hill Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS,
OR RECENT RESIDENTS)

At place _____ yrs. mos. ds. In the _____ State _____ yrs. mos. ds

Where was disease contracted,
if not at place of death? _____

Former or
usual residence _____

19 PLACE OF BURIAL OR REMOVAL Accomac Co. on farm DATE OF BURIAL Sept. 15, 1914

20 UNDERTAKER W. T. Dean ADDRESS Snow Hill

REVISED UNITED STATES STANDARD

CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonacum, etc.*, *Carcinoma*, *Sarcoma*, etc., of..... (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Contingent," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railroad train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture or skull, and consequences (e. g., *scrosis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

OCT 5 1914

BUREAU U. S.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

V. S. No. 1.

1 PLACE OF DEATH

County Worcester

9420

28

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 355

Village or City Showell (No.) Mill

St.: Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Dasy E. Hadder

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female	4 COLOR OR RACE White	5 SINGLE, MARRIED, WIDOWED, OLDWIDED (Write the word) Single
--------------	-----------------------	---

6 DATE OF BIRTH

Dec 3, 1890
(Month) (Day) (Year)

7 AGE

23 yrs. 9 mos. 18 ds.

If LESS than
1 day, hrs.
OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work.

House Work

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Maryland

PARENTS

10 NAME OF FATHER

Willie Hadder

11 BIRTHPLACE OF FATHER

(State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Mary Wedgeon

13 BIRTHPLACE OF MOTHER

(State or country)

Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Dasy E. Hadder

(Address) Showell Mill

15 Filed 9/23-1914 M. J. Bowesway

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Sept 21, 1914
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from Jan. 1, 1914, to Sept. 20, 1914,

that I last saw him alive on Sept. 20, 1914,

and that death occurred on the date stated above, at m.

The CAUSE OF DEATH was as follows:

Tuberculosis (consumption)

(Duration) 6 yrs. 8 mos. 21 ds.

Contributory
Secondary

(Duration) yrs. mos. ds.

(Signed) Rodin P. Collier, M. D.
Sept. 21, 1914 (Address) Bismarck, N.D.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,
If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

Taylorville Cemetery Sept. 22, 1914

20 UNDERTAKER

J. W. Burbage & Son Berlin, Md.

ADDRESS

REVISED UNITED STATES STANDARD

CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary foreman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry; and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Mauger," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma

"*Sarcoma*, etc., of..... (name origin, "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 d.; *Bronchopneumonia* (secondary), 10 d. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Contingual," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "*Puerperal septicæmia*," "*Puerperal peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH
County Worcester

9421

Village or City Snow Hill (No.)

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 3051

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Leonard S Hancock Jr.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male	4 COLOR OR RACE White	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)
------------	-----------------------	--

6 DATE OF BIRTH April 21, 1914
(Month) (Day) (Year)

7 AGE 0 yrs. 5 mos. 0 ds. OR min. ?
It LESS than 1 day, hrs.

8 OCCUPATION (a) Trade, profession, or particular kind of work. Driver
(b) General nature of industry, business, or establishment in which employed (or employer) Driver

9 BIRTHPLACE Maryland
(State or country)

10 NAME OF FATHER Leonard S Hancock

11 BIRTHPLACE OF FATHER Maryland
(State or country)

12 MAIDEN NAME OF MOTHER Jessie Shrockley

13 BIRTHPLACE OF MOTHER Maryland
(State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Leonard Hancock

(Address) Snow Hill, R.F.D.

15 Filed 9/22/1914 Recd by Smith

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 9/21, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from 9/20, 1914, to 9/21, 1914,
that I last saw him alive on 9/21, 1914,

and that death occurred on the date stated above, at 6 a.m.
The CAUSE OF DEATH* was as follows:

Gastro-Enteritis
(Duration) yrs. mos. 4 ds.

Contributory Secondary
(Duration) yrs. mos. ds.

(Signed) Easton, Md. 9/22, 1914 (Address) 9/22, 1914, M. D.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

20 UNDERTAKER ADDRESS

W. T. Head Snow Hill

REVISED UNITED STATES STANDARD

CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonacum, etc.*, *Carcinoma*, *Sarcoma*, etc., of..... (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Mesles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Anæmia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Confidential," "Seuile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "*Puerperal septicemia*," "*Puerperal peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means of INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as PROBABLY such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH		9122
County		Worcester
Village or City		Snowtree md
2 FULL NAME		Flarence Hayward
PERSONAL AND STATISTICAL PARTICULARS		
3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)
Female	colored	single
6 DATE OF BIRTH		
Dec 27		1899
(Month) (Day)		(Year)
7 AGE		
14 yrs.	8 mos.	23 ds.
8 OCCUPATION		
(a) Trade, profession, or particular kind of work		
School Girl		
(b) General nature of industry, business, or establishment in which employed (or employer)		
Same		
9 BIRTHPLACE (State or country)		
Snowtree md		
10 NAME OF FATHER		
Stephen Russell		
11 BIRTHPLACE OF FATHER (State or country)		
Worcester md		
12 MAIDEN NAME OF MOTHER		
annie Hayward		
13 BIRTHPLACE OF MOTHER (State or country)		
Worcester Co md		
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE		
(Informant)		Mary Hayward
(Address)		Snowtree md
15 Filed	9/22/1914	
	L E Roy Smith	

REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 305

St.; Ward

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

176

MEDICAL CERTIFICATE OF DEATH		
16 DATE OF DEATH		
Sept 20		, 1914 (Month) (Day)
I HEREBY CERTIFY, That I attended deceased from Sept 20, 1914, to Sept 20, 1914,		
that I last saw her alive on Sept 20, 1914,		
and that death occurred on the date stated above, at 10 P.M.		
The CAUSE OF DEATH* was as follows:		
Accident, Kicked by horse		
17 DURATION		
15 hours		hrs. mos. ds.
Contributory		
Secondary		
18 DURATION		
John L. Riley		hrs. mos. ds.
(Signed) Sept 21, 1914 (Address) Snowtree md		
* State the DISEASE CAUSING DEATH, or, In deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.		
19 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)		
At place of death yrs. mos. ds. In the State yrs. mos. ds.		
Where was disease contracted, If not at place of death?		
Former or usual residence		
20 PLACE OF BURIAL OR REMOVAL		
Elmwood Cemetery		DATE OF BURIAL Sept 22, 1914
21 UNDERTAKER		
H. S. Williams		ADDRESS Snowtree

REVISED UNITED STATES STANDARD

CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is Indefinite); *Tuberculosis of lung, meninges, peritoneum, etc.*, *Carcinoma*, *Sarcoma*, etc. of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Mesles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 d.; *Bronchopneumonia* (secondary), 10 d. Never report mere symptoms or terminal conditions, such as "Anæmia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Delirium," "Genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traenium," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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OCT 5 1914

BUREAU OF THE

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH
County *Hanover*

9423

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. *350*

St.: Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

Village or City *Towmash* (No.)2 FULL NAME *Thos J. Henderson Jr.*

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <i>Male</i>	4 COLOR OR RACE <i>white</i>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <i>✓</i>
-------------------	------------------------------	--

6 DATE OF BIRTH	<i>May 4th</i>	<i>1914</i>
	(Month)	(Day)
		(Year)

7 AGE	<i>47</i>	if LESS than 1 day, <u>hrs.</u> <u>0</u>
	mos. <i>11</i>	ds. <u>OR</u> min. ?

8 OCCUPATION	(a) Trade, profession, or particular kind of work <i>✓</i>
	(b) General nature of industry, business, or establishment in which employed (or employer) <i>✓</i>

9 BIRTHPLACE (State or country)	<i>Md.</i>
------------------------------------	------------

10 NAME OF FATHER	<i>Thos J. Henderson</i>
-------------------	--------------------------

11 BIRTHPLACE OF FATHER (State or country)	<i>Md.</i>
---	------------

12 MAIDEN NAME OF MOTHER	<i>Selma Lucy</i>
--------------------------	-------------------

13 BIRTHPLACE OF MOTHER (State or country)	<i>Md.</i>
---	------------

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant)	<i>Thos J. Henderson</i>
---	--------------------------

(Address)	<i>Thomash City</i>
-----------	---------------------

15 Filed <i>9/15</i> 1914	<i>Ephraim Hellman</i>
---------------------------	------------------------

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *Sept. 14th*

(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from

Aug 28th, 1914, to *Sept. 14th*, 1914,that I last saw him alive on *Sept. 13th*, 1914,and that death occurred on the date stated above, at *3:30 P.M.*

The CAUSE OF DEATH* was as follows:

Phantoms
(Duration) yrs. *15* mos. *0* ds.

Contributory *Lenters*
Secondary

(Duration) yrs. *1* mos. *0* ds.

(Signed) *J. M. Wilson* M. D.
Sept. 15th, 1914. (Address) *Thomash City*

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL *Methodist P. conne* DATE OF BURIAL *9/15*, 191420 UNDERTAKER *Stevenson Bros* ADDRESS *P. conne*

REVISED UNITED STATES STANDARD

CERTIFICATE OF DEATH

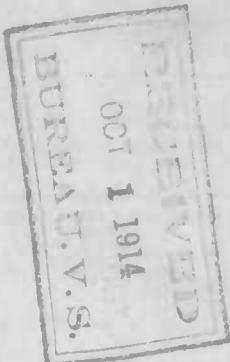
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Anemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Deliency" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent death state MEANS OF INJURY and QUALITY AS ACCIDENTAL, SUICIDAL, OR HOMICIDAL, OR AS *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probable suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *scaphis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH		9424
County	worcester	
Village or City	Berlin md (No.)	
2 FULL NAME <i>Elara E. Henry</i>		
PERSONAL AND STATISTICAL PARTICULARS		
3 SEX <i>Female</i>	4 COLOR OR RACE <i>Black</i>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <i>(Write the word)</i>
6 DATE OF BIRTH <i>May 21, 1914</i>		
7 AGE <i>4 yrs. 4 mos. 1 ds.</i>		
If LESS than 1 day, _____ hrs. OR min. ?		
8 OCCUPATION (a) Trade, profession, or particular kind of work. (b) General nature of industry, business, or establishment in which employed (or employer)		
9 BIRTHPLACE (State or country) <i>Maryland</i>		
10 NAME OF FATHER <i>Thurley Henry</i>	11 BIRTHPLACE OF FATHER (State or country) <i>Delaware</i>	
12 MAIDEN NAME OF MOTHER <i>Norma Berry</i>	13 BIRTHPLACE OF MOTHER (State or country) <i>Pennsylvania</i>	
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE		
(informant) <i>Norma Henry</i>	(Address) <i>Berlin md</i>	
15 Filed <i>9/24 1914</i>	16 <i>Whiteaway</i>	17 <i>Whiteaway</i>

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. *3.55*

St.: Ward)

[If death occurred in
a hospital or institution,
give its NAME instead
of street and number.]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH
Sep 19 1914

(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

Sep 19 1914, to *Sep 23 1914*

that I last saw him alive on *Sep 23 1914*and that death occurred on the date stated above, at *9 A.M.*

The CAUSE OF DEATH* was as follows:

Cholera dysentery

(Duration) *5 yrs. 5 mos. 5 ds.*Contributory
Secondary(Duration) *5 yrs. 5 mos. 5 ds.*

(Signed) *Grace G. Hall*, M. D.
Sept 24, 1914 (Address) *Berlin md*

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death *yrs. mos. ds.* In the State *yrs. mos. ds.*

Where was disease contracted,
If not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL *Berlin md* **DATE OF BURIAL** *Sept 24, 1914*

20 UNDERTAKER *Eliza J. Evans* **ADDRESS** *Berlin md*

REVISED UNITED STATES STANDARD

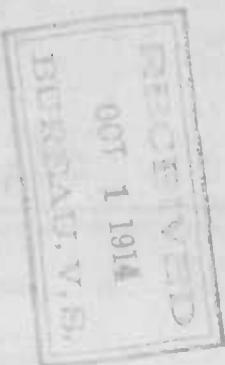
CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Plauter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic arteriolar heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Anemia," "Amaenia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "*Puerperal septicemia*," "*Puerperal peritonitis*," etc. State cause for which surgical operation was undertaken. For violent death state means of injury and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railroad train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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REVISED UNITED STATES STANDARD

CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma, *Sarcoma*, etc. of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Muscles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Masles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Mastitis," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "*Puerperal septicemia*," "*Puerperal peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railroad train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *scaphis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

County Worcester

9426

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 853

St. Ward

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

Village or City Burkittsville (No. 1)

Hudson

2 FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED
(Write the word)

Male

White

Single

6 DATE OF BIRTH

Sept

24, 1914

(Month)

(Day)

(Year)

7 AGE

yrs.

mos.

If LESS than
1 day, hrs.
ds. OR min. ?

8 OCCUPATION

- (a) Trade, profession, or particular kind of work. Nurse
 (b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Maryland

PARENTS

10 NAME OF FATHER

Burke Hudson

11 BIRTHPLACE OF FATHER

(State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Frannie Hudson

13 BIRTHPLACE OF MOTHER

(State or country)

Bishop Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) George Hudson

(Address) Bishop Md. R.R. #1, Box 1

15

Filed Sept 24, 1914 Garnett Raynor

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Sept 24, 1914

(Month)

(Day)

(Year)

Sept 24

1914

Sept 24

1914

that I last saw her alive on Sept 24, 1914

and that death occurred on the date stated above, at 11 A.M.

The CAUSE OF DEATH was as follows:

The mother
 was only pregnant 7
 months & it lay one
 week & 1 hour after birth
 (Duration) yrs. mos. ds.

Contributory
Secondary

(Duration) yrs. mos. ds.

(Signed)

Potter P. Corbin, M.D.

Sept 24, 1914

(Address)

Bishop Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,
if not at place of death?Former or
usual residence.

19 PLACE OF BURIAL OR REMOVAL

Lynck Cemetery

20 UNDERTAKER

W. J. Hudson

DATE OF BURIAL

Sept 25, 1914

ADDRESS

Bishop Md.

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonacum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor", for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Anemia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Malaria," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "*Puerperal septicæmia*," "*Puerperal peritonitis*," etc. State cause for which surgical operation was undertaken. For violent death—*MEANS OF INJURY* and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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OCT 2 1914

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1 PLACE OF DEATH
County *Baltimore*

Village or City *Cedar Hall* (No.)

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. *350*St. *Ward*)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME *Mary C. Lambden*

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <i>Female</i>	4 COLOR OR RACE <i>white</i>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <i>MARRIED</i>
---------------------	------------------------------	---

6 DATE OF BIRTH <i>Nov 10 1856</i>	(Month)	(Day)	(Year)
------------------------------------	---------	-------	--------

7 AGE <i>64 yrs. 10 mos. 0 ds.</i>	If LESS than 1 day, _____ hrs. OR _____ min. ?
------------------------------------	--

8 OCCUPATION (a) Trade, profession, or particular kind of work <i>Housewife</i>	(b) General nature of industry, business, or establishment in which employed (or employer) <i>✓</i>
--	---

9 BIRTHPLACE (State or country) <i>Md.</i>

10 NAME OF FATHER <i>Donald Brown</i>

11 BIRTHPLACE OF FATHER (State or country) <i>Donald Brown</i>

12 MAIDEN NAME OF MOTHER <i>Donald Brown</i>
--

13 BIRTHPLACE OF MOTHER (State or country) <i>Donald Brown</i>

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *J. J. Lambden*

(Address) *Laurelton City*

Filed *Sept. 16, 1916* by *Ephraim Hellman*

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *Sept. 14th, 1916*

(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from *Sept. 13th, 1916* to *Sept. 14th, 1916*,
that I last saw *her* alive on *Sept. 14th, 1916*,
and that death occurred on the date stated above, at *4 P.M.*
The CAUSE OF DEATH* was as follows:

Malnutrition for *two hours*
(Duration) yrs. mos. ds.

Contributory
Secondary *None*

(Duration) yrs. mos. ds.
(Signed) *J. J. Lambden*, M. D.
Sept. 15th, 1916 (Address) *Laurelton City*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL *Methodist Church* DATE OF BURIAL *Sept. 16, 1916*20 UNDERTAKER *Sorenson Bros.* ADDRESS *Promised*

Mervin M. Bird

REVISED UNITED STATES STANDARD

CERTIFICATE OF DEATH

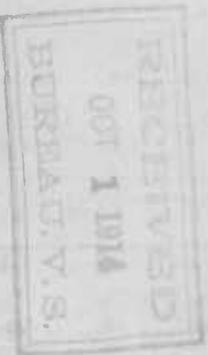
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Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum, etc., Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); Measles; Whooping cough; Chronic catarrhal heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: Measles (disease causing death), 29 d.; Bronchopneumonia (secondary), 10 d. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Seizure," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Tetraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; Struck by railroad train—accident; Revolver wound of head—Homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g., scaphis, tetanus) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Maryland

9428

(2)

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 353Village or City Silbyville Del (No. RFD 401)

St. _____ Ward _____

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Kenneth J. Magel, or Hudson

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Single</u> (Write the word)
-------------------	------------------------------	---

6 DATE OF BIRTH

July 8, 1913
(Month) (Day) (Year)

7 AGE

1 yrs. 2 mos. 18 ds.
If LESS than
1 day, _____. hrs.
OR _____. min. ?

8 OCCUPATION

- (a) Trade, profession, or particular kind of work.
 (b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER
(State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Lydia J. Magel(Address) Silbyville Del RFD 401

15

Filed Sept 27, 1914 Timothy Rayne

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Sept 27, 1914 (Month) (Day) (Year)I HEREBY CERTIFY, That I attended deceased from Sept 18, 1914, to Sept 20, 1914,that I last saw him alive on Sept 18, 1914, 1914,and that death occurred on the date stated above, at 2138 P.M.

The CAUSE OF DEATH* was as follows:

Heart disease

(Duration) yrs. mos. ds.

Contributory
Secondary

(Duration) yrs. mos. ds.

(Signed) Sept 27, 1914 (Address) Peter C. Klein M. D.

*State the DISEASE CAUSING DEATH, or, In deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place _____ in the _____
of death yrs. mos. ds. State yrs. mos. ds.Where was disease contracted,
if not at place of death?Former or
usual residence.

19 PLACE OF BURIAL OR REMOVAL

Long cemeter DATE OF BURIAL Sept 27, 1914

20 UNDERTAKER

J. F. Matson ADDRESS Silbyville Del.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples:

(a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer*—*Cook* *minc*, etc. Women at home, who are engaged in the duties of the household only (not paid *Hauskeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housmaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*) For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonacum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: *Measles* (disease causing death), *29 d.s.*; *Bronchopneumonia* (secondary), *10 d.s.* Never report mere symptoms or terminal conditions, such as "Anæmia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "*PUERPERAL septicemia*," "*PUERPERAL peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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OCT 2 1914

A. T. V. S.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

1 PLACE OF DEATH 9429
County *Hanover*

Village or City *Towomoke* (No.)

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 350

St. _____ Ward _____

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME *Harley S. Miller*

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)
male	white	<input checked="" type="checkbox"/>

6 DATE OF BIRTH *Mar 7th*, 1914
(Month) (Day) (Year)

7 AGE *4 yrs. 25 mos. 25 ds.* If LESS than
1 day, ____ hrs.
OR ____ min. ?

8 OCCUPATION
(a) Trade, profession, or
particular kind of work
(b) General nature of industry,
business, or establishment in
which employed (or employer)

9 BIRTHPLACE
(State or country) *Md.*

10 NAME OF FATHER *C. H. Miller*
11 BIRTHPLACE OF FATHER (State or country) *Md.*
12 MAIDEN NAME OF MOTHER *Susie Raley*
13 BIRTHPLACE OF MOTHER (State or country) *Md.*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *C. H. Miller*
(Address) *Towomoke City*

15 Filed *9/2 1914* *Ehman Miller*

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *Sept. 1st, 1914*
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from *Sept. 1st, 1914* to *Sept. 1st, 1914*,
that I last saw him alive on *Sept. 1st, 1914*,
and that death occurred on the date stated above, at *3:30 P.M.*
The CAUSE OF DEATH* was as follows:

Dysentery collapse *fee based*
(Duration) yrs. mos. ds.

Contributory *Bacteritis*
Secondary

(Duration) yrs. mos. ds.

(Signed) *J. M. Miller*, M. D.
Sept. 2nd, 1914 (Address) *Towomoke City*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL *Melvin Cemetery* DATE OF BURIAL *9/2 1914*

20 UNDERTAKER *Stevenson Bros* ADDRESS *Picadilly*

REVISED UNITED STATES STANDARD

CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age.

For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples:

(a) *Spinner*; (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer*—*Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*) For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lung, meninges, peritonacum*, etc., *Carcin-*

oma, *Sarcoma*, etc. of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Anemia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "*Puerperal septicemia*," "*Puerperal peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train*—accident; *Revolver wound of head*—homicide; *Poisoned by carbolic acid*—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

OCT 1 1914

BUREAU U. S. A.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

9430

County. Worcester

Village or City Snowflake Md (No.)

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 351

St. _____ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Francis Purnell

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED
(Write the word)

single

6 DATE OF BIRTH

May 5

, 1914

(Month)

(Day)

(Year)

7 AGE

yrs.

mos.

ds.

IF LESS than
1 day, ____ hrs.
OR ____ min. ?

8 OCCUPATION

(a) Trade, profession, or
particular kind of work.

None

(b) General nature of industry,
business, or establishment in
which employed (or employer)

None

9 BIRTHPLACE

(State or country)

Snowflake Md

PARENTS

10 NAME OF FATHER

Martindale Purnell

11 BIRTHPLACE OF FATHER

(State or country)

Worcester Co Md

12 MAIDEN NAME OF MOTHER

Mildred Selby

13 BIRTHPLACE OF MOTHER

(State or country)

Greenback Va

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Martindale Purnell

(Address) Snowflake Md

15

Filed 9/9, 1914

By L. Roy Smith

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Sept 6th

, 1914

(Month)

(Day)

(Year)

17 I HEREBY CERTIFY, That I attended deceased from

....., 191..... to , 191.....

that I last saw h alive on , 191.....

and that death occurred on the date stated above, at 10.00 a.m.

The CAUSE OF DEATH* was as follows:

No Physician

Infantile diarrhea

(Duration) yrs. mos. ds.

Contributory

Secondary

(Duration) yrs. mos. ds.

(Signed)

Sept 6th, 1914

(Address)

Paul Jones, M. D.
Snowflake Md

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

Baptist Cemetery

DATE OF BURIAL
Sept 6, 1914

20 UNDERTAKER

H. S. Williams

ADDRESS
Snowflake

REVISED UNITED STATES STANDARD

CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples:

(a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum, etc., Cancer*,

oma, Sarcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic arteriolar heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 d.s.; *Bronchomeningitis* (secondary), 10 d.s. Never report mere symptoms or terminal conditions, such as "Anæmia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Delirium" ("Confusional," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traæmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "*Puerperal septicæmia*," "*Puerperal peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railroad train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., sepsis, tetanus) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

OCT 5 1914

BUREAU V.S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Worcester
9431

Village or City Snow Hill (No.)

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 357

St. Ward

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Ashur T. Richardson

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male	4 COLOR OR RACE white	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED married (Write the word)
------------	-----------------------	---

6 DATE OF BIRTH Sept 21, 1855
(Month) (Day) (Year)

7 AGE 58 yrs. 11 mos. 23 ds.
If LESS than 1 day, hrs.
OR min. ?

8 OCCUPATION Capitalist
(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE Maryland
(State or country)

10 NAME OF FATHER Littleton J. Richardson

11 BIRTHPLACE OF FATHER Maryland
(State or country)

12 MAIDEN NAME OF MOTHER Harriet E. Scarborough

13 BIRTHPLACE OF MOTHER Maryland
(State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Virginia L. Nash

(Address) Philadelphia

15 Filed 9/15, 1914
4 LeRoy Smith

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept 14, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Aug 22, 1914, to Sept 14, 1914,

that I last saw him alive on Sept 14, 1914,

and that death occurred on the date stated above, at 6:30 P.M.

The CAUSE OF DEATH* was as follows:

Dialetis mellitus

(Duration) 2 yrs. 0 mos. 0 ds.

Contributory
Secondary

(Duration) 1 yrs. 0 mos. 0 ds.

(Signed) John L. Rice, M.D.
Sept 14, 1914 (Address) Snow Hill, Md.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Ashton, Texas
DATE OF BURIAL (2), 1914

20 UNDERTAKER W.T. Dean Snow Hill
ADDRESS

REVISED UNITED STATES STANDARD

CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*; (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer*—*Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewifc*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housmaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired* 6 yrs.) For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Tuberous pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonacum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: *Masles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Anemia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Delirium" ("Confusional"), "Senile," etc., "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "*Puerperal septicemia*," "*Puerperal peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED	Oct 6 1914
U.S. REVENGE. V.S.	

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: *Masles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Anemia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Delirium" ("Confusional"), "Senile," etc., "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "*Puerperal septicemia*," "*Puerperal peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

V. S. No. 1.

1 PLACE OF DEATH County <i>Worcester</i>		9432
Village or City <i>Snow Hill</i> (No.)		<i>CH</i>
2 FULL NAME <i>Harriet E. Richardson</i>		
PERSONAL AND STATISTICAL PARTICULARS		
3 SEX <i>Female</i>	4 COLOR OR RACE <i>White</i>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <i>Widow</i> (Write the word)
6 DATE OF BIRTH <i>Sept. 23, 1826</i>		(Month) (Day) (Year)
7 AGE <i>87 yrs. 11 mos. 23 ds.</i>	If LESS than 1 day, hrs. OR min. ?	
8 OCCUPATION (a) Trade, profession, or particular kind of work <i>None</i>		
(b) General nature of industry, business, or establishment in which employed (or employer) <i>None</i>		
9 BIRTHPLACE (State or country) <i>Maryland</i>		
10 NAME OF FATHER <i>Richard Scarborough</i>		
11 BIRTHPLACE OF FATHER (State or country) <i>Maryland</i>		
12 MAIDEN NAME OF MOTHER <i>Harriet E. White</i>		
13 BIRTHPLACE OF MOTHER (State or country) <i>Maryland</i>		
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <i>Leslie Smith</i> (Address) <i>Laredo, Texas</i>		
15 Filed <i>9/19, 1911</i>	4 RELOY SMITH	REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. *35*

St. Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *Sept 17, 1914*
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from *Aug 13, 1914*, to *Sept 17, 1914*,

that I last saw her alive on *Sept 17, 1914*

and that death occurred on the date stated above, at *5 P.M.*

The CAUSE OF DEATH* was as follows:

Hemiplegia

(Duration) yrs. 1 mos. 4 ds.

Contributory
Secondary

(Duration) yrs. 2 mos. ds.

(Signed) *John L. Bailey*, M. D.

(Address) *Snow Hill Md.*

State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) WHETHER ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place _____ yrs. _____ mos. _____ ds. In the _____ State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, If not at place of death?

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL
In E Cemetery Snow Hill Sept 19, 1914

20 UNDERTAKER ADDRESS
W.T. Frame Snow Hill

REVISED UNITED STATES STANDARD

CERTIFICATE OF DEATH

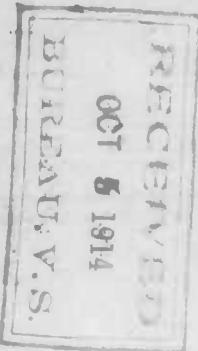
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocer; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcin-*

*oma, Sarcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intervening) affection need not be stated unless important. Example: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Confused," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Mastitis," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: Accidental drowning; Struck by railroad train—accident; Recovery wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g., sepsis, tetanus) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)*

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

County Worcester

9433

79

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 355

St.: _____ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

Village or City Berlin md (No. _____)2 FULL NAME John Rider

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

Male colored widowed
5 SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED
(Write the word)

6 DATE OF BIRTH

Nov. 20, 1862 about-
(Month) (Day) (Year)

7 AGE

52

yrs.

mos.

If LESS than
t day, _____ hrs.
OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer)

Former

9 BIRTHPLACE

(State or country)

Maryland

PARENTS

10 NAME OF FATHER

George Rider

11 BIRTHPLACE OF FATHER

(State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Larah Pitts

13 BIRTHPLACE OF MOTHER

(State or country)

Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Marietta Purcell(Address) Berlin md

15

9/20/1914Filed W.L. Halloway

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Sept 16, 1914
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from

May, 1914, to Sept 16, 1914,

that I last saw him alive on Sept 16, 1914,and that death occurred on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Acute Respiratorymos

(Duration) yrs mos ds.

Contributory
SecondaryGrippe

(Duration) yrs mos ds.

(Signed)

Elo Holland, M.D.Sept 17, 1914 (Address) Berlin md

*State the DISEASE CAUSING DEATH, or, In deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs mos ds. In the State yrs mos ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

Berlin mdSept 19, 1914

20 UNDERTAKER

Bertha J. EvansBerlin md

ADDRESS

REVISED UNITED STATES STANDARD

CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum, etc., Cancer-*

*oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: Measles (disease causing death), 29 d.s.; Bronchopneumonia (secondary), 10 d.s. Never report mere symptoms or terminal conditions, such as "Anæmia," "Anaemia" (merely symptomatite), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Contingent," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traëma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g., septis, tetanus) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)*

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1 PLACE OF DEATH

9434

County Worcester

(1)

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 853

St. _____ Ward _____

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

Village or City Whaleyville R.F.D. No. 1

2 FULL NAME

Frank Scott,

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White5 SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED
(Write the word)Single

6 DATE OF BIRTH

July6, 1914
(Month) (Day) (Year)

7 AGE

— yrs.1 mos.27 ds.
OR min.?

8 OCCUPATION

- (a) Trade, profession, or particular kind of work
Stanbury Service
- (b) General nature of industry, business, or establishment in which employed (or employer)
Stanbury Service

9 BIRTHPLACE
(State or country)Maryland

PARENTS

10 NAME OF FATHER

Stanbury Scott11 BIRTHPLACE OF FATHER
(State or country)Maryland

12 MAIDEN NAME OF MOTHER

Liz. West13 BIRTHPLACE OF MOTHER
(State or country)Delaware

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Stanbury Scott(Address) Whaleyville R.F.D. No. 1

15

Filed Sept 3, 1914 by Gairn Thy Rayne

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Sept31914
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from Wesley Scott, 1914, to Sept 3, 1914.that I first saw him alive on Sept 3, 1914.and that death occurred on the date stated above, at 3:00 P.M.

The CAUSE OF DEATH* was as follows:

No DoctorNo Doctor

(Duration) yrs. mos. ds.

Contributory
Secondary

(Duration) yrs. mos. ds.

(Signed) Gairn Thy Rayne, M. D.(Address) Bishop Rd

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

Cemetery Sept 3, 1914

DATE OF BURIAL

20 UNDERTAKER

P F Nations

ADDRESS

Sallyville, Del.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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(a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum, etc.*, *Carcin-*

oma, Sarcoma, etc., of..... (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Anemia," "Anaemia," merely symptomatic); "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Scielle," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicemia," "puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH
County Worcester 9435
(152)

Village or City Berlin (No.)

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 355

St.: _____ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME No maine

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Male</u>	4 COLOR OR RACE <u>Cal</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)
-------------------	----------------------------	--

6 DATE OF BIRTH Sypt 3 1914, 1
(Month) Day (Year)

7 AGE — yrs. — mos. 2 ds.
If LESS than
1 day, ____ hrs.
OR ____ min. ?

8 OCCUPATION
(a) Trade, profession, or
particular kind of work
(b) General nature of industry,
business, or establishment in
which employed (or employer)

9 BIRTHPLACE Near Berlin
(State or country)

10 NAME OF FATHER Daniel Showell

11 BIRTHPLACE OF FATHER Maryland
(State or country)

12 MAIDEN NAME OF MOTHER Lizzie Burnell

13 BIRTHPLACE OF MOTHER Maryland
(State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Daniel Showell
(Address) Berlin Md

15 Filed Sypt 6 1914 W. H. Holloway

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sypt 5 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from 9-3-1914 to 9-5-1914,

that I last saw him alive on 9-4-1914,

and that death occurred on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Haemophilia
slight trauma
(Duration) yrs. mos. ds.

Contributory
Secondary

(Duration) yrs. mos. ds.

(Signed) Chas R. Low, M. D.
9-5-1914 (Address) Berlin Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place _____
of death _____ yrs. ____ mos. ____ ds. In the _____ State _____ yrs. ____ mos. ____ ds

Where was disease contracted,
if not at place of death?

Former or
usual residence _____

19 PLACE OF BURIAL OR REMOVAL St Pauls Cemetery Sypt 6, 1914
DATE OF BURIAL

20 UNDERTAKER W. Bushnell Jr. ADDRESS Berlin Md

REVISED UNITED STATES STANDARD

CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary foreman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housmaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*) For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., or (name origin: "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 d.; *Bronchopneumonia* (secondary), 10 d. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatite), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Tropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent death state MEANS OF INJURY and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

1 PLACE OF DEATH 9436

County Worcester

Village or City Bear Snow Hill (No.)

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 357

St. Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Jerome Victor

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male	4 COLOR OR RACE Colored	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Singh
------------	-------------------------	--

6 DATE OF BIRTH June 17th, 1912
(Month) (Day) (Year)

7 AGE 2 yrs. 3 mos. 5 ds. If LESS than 1 day, hrs. OR min.?

8 OCCUPATION (a) Trade, profession, or particular kind of work... none
(b) General nature of industry, business, or establishment in which employed (or employer) ... none

9 BIRTHPLACE (State or country) Worcester Co. Md

10 NAME OF FATHER Jacob E. Victor

11 BIRTHPLACE OF FATHER (State or country) Worcester Co. Md

12 MAIDEN NAME OF MOTHER Mary Sturgis

13 BIRTHPLACE OF MOTHER (State or country) Worcester Co. Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Jacob E. Victor

(Address) Snow Hill Md

15 Filed 9/6, 1914 L E Roy Smith

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept. 4th, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY That I attended deceased from Sept. 1, 1914, to Sept 4, 1914,

that I last saw him alive on Sept 3, 1914,

and that death occurred on the date stated above, at 6 a.m.,

The CAUSE OF DEATH* was as follows:

Acute Gastro-enteritis

(Duration) yrs. mos. 7 ds.

Contributory Secondary

(Duration) yrs. mos. ds.

(Signed) E. E. Kishhart, M. D.

Sept. 4, 1914 (Address) Snow Hill, Md.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Hutchings Cemetery

DATE OF BURIAL Sept. 4, 1914

20 UNDERTAKER J. P. Williams

ADDRESS 1907 Williams

REVISED UNITED STATES STANDARD

CERTIFICATE OF DEATH

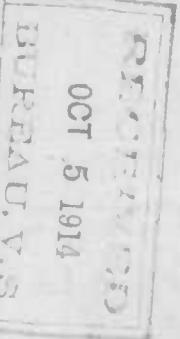
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*) For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "*Puerperal septicemia*," "*Puerperal peritonitis*," etc. State cause for which surgical operation was undertaken. For violent death state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *retusus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

OCT 5 1914



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH 9437

County Worcester

Village or City Snow Hill Md (No.)

2 FULL NAME Margie Ward

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female	4 COLOR OR RACE Colored	5 SINGLE, MARRIED, WIDOWED, DIVORCED (Write the word) Single
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6 DATE OF BIRTH May 8th, 1892
(Month) (Day) (Year)

7 AGE 22 yrs. 4 mos. ds. If LESS than
1 day, hrs. OR min. ?

8 OCCUPATION Servis Girl
(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer) Same

9 BIRTHPLACE Worcester Co Md
(State or country)

10 NAME OF FATHER Albert Ward

11 BIRTHPLACE OF FATHER Worcester Co Md
(State or country)

12 MAIDEN NAME OF MOTHER Annie Ward

13 BIRTHPLACE OF MOTHER Worcester Co Md
(State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Watson Purcell

(Address) Snow Hill Md

15 Filed 9/10/1914 L. Leroy Smith

REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 357

St. Ward

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 9 8 , 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from 8/16, 1914 to 8/23, 1914,
that I last saw her alive on 8/23, 1914,

and that death occurred on the date stated above, at 8:30 P.M.

The CAUSE OF DEATH was as follows:

J. D. Lungs.

(Duration) yrs. 11 mos. ds.

Contributory
Secondary

(Duration) yrs. mos. ds.

(Signed) 9/10/1914 (Address) Maryland, D. Luogo, M. D.
Worcestor Co Md

(Address)

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) WHETHER ACCIDENTAL, SUICIDAL, OR HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

M. T. Wesley Cemetery, Balt., 1914

20 UNDERTAKER ADDRESS

W. J. Williams Snow Hill Md

REVISED UNITED STATES STANDARD

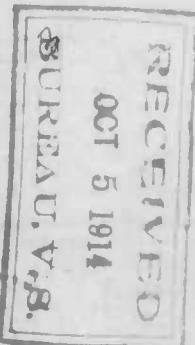
CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary foreman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as "*Day laborer, Farm laborer, Laborer—Coal mine, etc.*" Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: "*Epidemic cerebrospinal meningitis*"; *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "*Typhoid pneumonia*"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Cancer,* etc., *Sarcoma*, etc., of (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Anemia," "Amaenia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Contingent," "Seville," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "*PUERPERAL septicemia*," "*PUERPERAL peritonitis*," etc. State cause for which surgical operation was undertaken. For violent death state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH County..... <i>Hanover</i>		9438
Village or City (No.) <i>Towmukie</i>		<i>Si</i>
2 FULL NAME.....		<i>W.H. White</i>
PERSONAL AND STATISTICAL PARTICULARS		
3 SEX <i>Female</i>	4 COLOR OR RACE <i>white</i>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <i>S</i>
6 DATE OF BIRTH <i>Sept 28</i>		(Month) (Day) (Year) <i>(Month) (Day) (Year)</i>
7 AGE <i>✓ yrs. ✓ mos. ✓ ds.</i>	If LESS than 1 day, hrs. OR min. ?	
8 OCCUPATION (a) Trade, profession, or particular kind of work <i>✓</i> (b) General nature of industry, business, or establishment in which employed (or employer) <i>✓</i>		
9 BIRTHPLACE (State or country) <i>Md.</i>		
10 NAME OF FATHER <i>Harry J. White</i>		
11 BIRTHPLACE OF FATHER (State or country) <i>Md.</i>		
12 MAIDEN NAME OF MOTHER <i>Bess T. Lupina</i>		
13 BIRTHPLACE OF MOTHER (State or country) <i>Md.</i>		
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <i>Harry J. White</i> (Address) <i>Towmukie Ctry</i>		
15 Filed <i>9/29 1914</i>	Ephraim Hellman	REGISTRAR

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balt., Requesting V. S. No. 1.

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. *330*

St.: Ward)

[If death occurred in
a hospital or institution,
give its NAME instead
of street and number.]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH
Sept 28, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

✓, 1914, to *✓*, 1914,

that I last saw *h.v.* alive on *✓*, 1914,

and that death occurred on the date stated above, at *✓* m.,

The CAUSE OF DEATH* was as follows:

Still Birth
(Duration) yrs. mos. ds.

Contributory
Secondary

(Duration) yrs. mos. ds.

(Signed) *J. Wilson*, M. D.

Sept 28, 1914 (Address) *Stowmukie Ctry*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Episcopal Cemetery *Sept 29, 1914*

20 UNDERTAKER ADDRESS

Stowmukie Inn *Pocomoke*

REVISED UNITED STATES STANDARD

CERTIFICATE OF DEATH

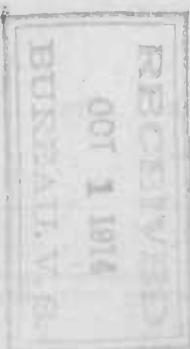
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum, etc., Cancer-*

*oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); Measles; Whooping cough; Chronic tubular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: Measles (disease causing death), 29 ds.; Bronchomeningitis (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Anemia," "Alæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Seuile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g., sepsis, tetanus) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)*

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1 PLACE OF DEATH
County Worcester

Village or City Berlin (No. R. H. D.)

9439

(189)

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 355

St. _____ Ward)

[If death occurred in
a hospital or institution,
give its NAME instead
of street and number.]Elwood James Williams

2 FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)
<u>Male</u>	<u>White</u>	<u>Single</u>

6 DATE OF BIRTH
May 8, 1914
(Month) (Day) (Year)

7 AGE
..... yrs. 3 mos. 23 ds. If LESS than
1 day, ____ hrs.
OR ____ min. ?

8 OCCUPATION

- (a) Trade, profession, or particular kind of work
- (b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE
(State or country)

10 NAME OF FATHER
Levell Pruitt

11 BIRTHPLACE OF FATHER
(State or country)

12 MAIDEN NAME OF MOTHER
Cessie Williams

13 BIRTHPLACE OF MOTHER
(State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Cessie Williams

(Address) Berlin, Md.

15 Filed 9/2, 1914 W. L. Holloway
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH
Sept. 1, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

..... to , 1914,

that I last saw him alive on , 1914,

and that death occurred on the date stated above, at m.,

The CAUSE OF DEATH* was as follows:

no dr. in attendance

(Duration) yrs. mos. ds.

Contributory
Secondary

(Signed) W. L. Holloway, M. D.
30, 1914 (Address) Berlin, Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR REGENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL
Berlin, Md. DATE OF BURIAL
9/2, 1914

20 UNDERTAKER
Curtis J. Evans ADDRESS
Berlin —
Md.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples:

(a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Contract*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*) For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor", for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "*Puerperal septicæmia*," "*Puerperal peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Recover wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

OCT 1 1914

RECEIVED
BUREAU, V. S.

REC'D
DEC 1 1914



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH		9440
County		Worcester
Village or City		Near Snow Hill, Md.
2 FULL NAME		
G. E. R. Young		
PERSONAL AND STATISTICAL PARTICULARS		
3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)
Male	Colored	Single
6 DATE OF BIRTH		
March 29, 1893		
(Month) (Day) (Year)		
7 AGE		
20 yrs.	4 mos.	28 ds.
If LESS than 1 day, hrs. OR min.?		
8 OCCUPATION		
(a) Trade, profession, or particular kind of work.		
Farmer		
(b) General nature of industry, business, or establishment in which employed (or employer)		
Dance		
9 BIRTHPLACE (State or country)		
Accomack Co		
10 NAME OF FATHER		
Frank E. Young		
11 BIRTHPLACE OF FATHER (State or country)		
Accomack Co		
12 MAIDEN NAME OF MOTHER		
Lyda Savage		
13 BIRTHPLACE OF MOTHER (State or country)		
Accomack Co		
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE		
(Informant)		
Frank E. Young		
(Address)		
Snow Hill, Md.		
15	Filed	9/28, 1914
		Leroy Smith

If more blanks are needed, address State Registrar, 6 N. Franklin St., Balt., Requesting V. S. No. 1.

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 351

St. Ward

[If death occurred in
a hospital or institution,
give its NAME instead
of street and number.]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 9-28, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from
8/28, 1914, to 8/28, 1914

that I last saw him alive on 8/27, 1914
and that death occurred on the date stated above, at 4:30 p.m.

The CAUSE OF DEATH* was as follows:

Typhoid fever

(Duration) yrs. 1 mos. 15 ds.

Contributory
Secondary

(Duration) yrs. 0 mos. 0 ds.

(Signed) 9/28, 1914 (Address) Maryland, Md.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, OR REMOVAL DATE OF BURIAL

Whitewell Cemetery Sept. 30, 1914

20 UNDERTAKER ADDRESS

John Williams Sunbury, Md.

REVISED UNITED STATES STANDARD

CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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